

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County HarfordCity or town Aberdeen Proving Ground, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Six Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Texas County Mc LennaCity or town Mc Gregor Texas
(If outside city or town limits, write RURAL and give nearest town)Street No. Box 126
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Johnnie W. Anderson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 31 January 1927

8. AGE: Years Months Days If less than one day

19611

hrs. min.

9. Birthplace Mc Gregor, Texas
(Town, county, and state)10. Usual occupation Soldier, U. S. Army

11. Industry or business

12. Name Marshall Albert Anderson13. Birthplace Unknown14. Maiden name Hollie Mae (Anderson)

15. Birthplace

16. Informant U.S. Army RecordsAddress Aberdeen Proving Ground Md17. Funeral Home Date thereof Aug 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory In Funeral HomeLocation Mc Gregor, Texas18. Funeral director Howard E. McGinnisAddress Aberdeen Maryland19. Aug 20 19 46 Nellie H. Riley
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 46 at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Wound, penetrating skull DURATION
crushing of cerebellum medullaDue to Crushing in automobile accident

Due to

Other conditions Multiple Abrasions and
Lacerations
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, Automobile Date of 12 August 46Where did injury occur? Aberdeen Proving Ground
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Military ReservationMeans of Injury Automobile Accident Injured at work?

Undetermined

23. SIGNATURE Geo. K. Krumm M. D. or otherAddress Station Hosp APG Date signed 13 Aug 46Howard E. McGinnis

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
AUG 23 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18a

CERTIFICATE OF DEATH

08090 183
Reg. Dist. No.

1. PLACE OF DEATH:

County Harford
City or town Houder mill Rd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Harford
City or town Houder mill Road
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Jarrettsville
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Virginia Martha Baughes

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1946

8. AGE: Years Months Days If less than one day
- 5 15 hrs. min.9. Birthplace Balto md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Thornton merlin Baughes

13. Birthplace Chicago Ill

14. Maiden name Clara L. Preston

15. Birthplace Bare Hills md

16. Informant Mrs Thornton M Baughes

Address White Hall md

17. Burial Date thereof Aug 23 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Hill

Location Buena Vista, Va

18. Funeral director Martin & Smith

Address Jarrettsville md

19. Date rec'd by registrar Aug 23 1946

Registrar Thomas R Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1946, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Asphyxiation - accidental

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of Aug. 20, 1946

Where did injury occur Jarrettsville Harford md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Asphyxiation under matters injured at work?

23. SIGNATURE J. P. Laurey M.D.

M.D. or other

Address Aberdeen, md Date signed Aug. 20, 1946

RECEIVED
AUG 28 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08091

Reg. Diat. No. 182

1. PLACE OF DEATH:

County Hartford
 City or town Bel Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Li. 70 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Hartford
 City or town Bel Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Harriett Ellen Bond

3. (b) Social Security Number

4. Sex F 5. Color or race Col 6. (a) Single, married, widowed, or divorced W.
 6. (b) Name of husband or wife Wm E Bond
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb 15 - 1859
 8. AGE: Years 87 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Berryman, Hartford Co., Md
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER
 12. Name Henry Hollingsworth
 13. Birthplace Md

MOTHER
 14. Maiden name Eliza Hollingsworth
 15. Birthplace Md

16. Informant John Bond
 Address Bel Air, Md

17. Burial Date thereof Aug 28 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hendon Hill

Location Near Bel Air, Md.

18. Funeral director Dean & Fisher
 Address Bel Air Md

19. 8/27 19 46 Priscilla Toward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 19 46, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 19 46 to Aug 25 19 46 and that I last saw her alive on near Aug 23 19 46

Immediate cause of death Carcinoma of Stomach DURATION 18 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____ Date of op. _____

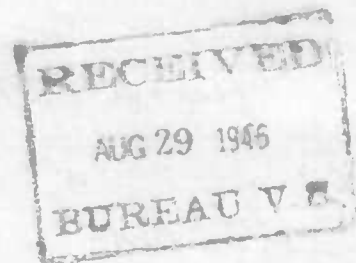
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson M. D. or other _____
 Address Forest Hill Md Date signed 8/26/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

Reg. Dist. No. 185

08092

1. PLACE OF DEATH: *Harford*
 County... *Harford*
 City or town... *Harford*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... *MD* County... *Harford*
 City or town... *Harford*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *568 Green St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME *Reese Norris Burns*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
 6.(b) Name of husband or wife *Edith M. Burns*
 6.(c) If alive, give age *69* years
 7. Birth date of deceased (mo., day, yr.) *Nov. 10, 1870*

8. AGE: Years *75* Months *8* Days *24* If less than one day
 hrs. min.

9. Birthplace... *Cecil G. Md.*
 (Town, county, and state)
 10. Usual occupation... *Real Estate*

11. Industry or business *Geo. A. Burns*

12. Name... *Geo. A. Burns*

13. Birthplace... *Md.*

14. Maiden name... *Anna Priest*

15. Birthplace... *Md.*

16. Informant... *Mrs. Edith M. Burns*

Address... *568 Green St. Harford, Md.*

17. *Burial* Date thereof... *Aug. 7 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... *Angel Hill Cem.*

Location... *Harford, Md.*

18. Funeral director... *H. Madison Mitchell*

Address... *Harford, Md.*

19. *8/5/46* 19... *4. F. Lewis M. D.*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *Aug. 4* 19... *46* at *1:45* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *8-4* 19... *46* to *8-4* 19... *46*
 and that I last saw him alive on *8-3-4* 19... *46*

Immediate cause of death... *Cerebral Hemorrhage*

Due to... *Hypertension*

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *James E. Macaulay M.D.*

Address... *500 Union Ave. Harford, Md.* Date signed... *8-5-46*

RECEIVED
AUG 8 1946
BUREAU V.E.

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Evidence for addition of
approximate age of deceased
is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08093/85-

FILM No. 106 AUG 19 1946

1. PLACE OF DEATH:

County HARFORD
City or town HARRE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 HOUR
Hospital, institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
How long in hospital or institution? 1 HOUR

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil
City or town C.O.P.R.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war. ☒

3. (a) FULL NAME

ELLEN

CAUDILL

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mack Caudill 6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) _____
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.
Approx. 52

9. Birthplace Sparta, North Carolina
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business _____
12. Name Daniel Crouse
13. Birthplace North Carolina
14. Maiden name Unknown
15. Birthplace _____

16. Informant Oscar Caudill
Address 126 Wilson St. Harrodsburg
17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 14, 1946
(Month) (day) (year)

Cemetery or crematory Mt. Zion Cem.
Location Harford Co. Md.
18. Funeral director A.S. Bailey
Address Darlington Md.
Aug 11, 1946 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH AUGUST 11, 1946 at 12:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
and that I last saw him _____ alive on _____ 19____
Immediate cause of death _____
CEREBRAL CONCUSSION
SHOCK, HEMORRHAGE
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____
Date of op. _____

Autopsy results NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ACCIDENT Date of Aug 11, 1946
Where did injury occur? NEAR CHURCHVILLE HARFORD MD.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) PUBLIC ROAD #136
Means of Injury AUTO ACCIDENT Injured at work? No

23. SIGNATURE J. W. Ramsey M.D.
DEP. MED. EXAMINER
Address Aberdeen, Md. Date signed Aug 11, 1946

RECEIVED
AUG 13 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17002

CERTIFICATE OF DEATH

Reg. Dist. No.

08094

18 2

1. PLACE OF DEATH:

County HARFORDCity or town RURAL - CHURCHVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

ROUTE # 136

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CecilCity or town Colara
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MACK DANIEL CAUDILL

3. (b) Social Security Number

NO4. Sex Male Color or race White6. (a) Single, married, ~~widowed, and divorced~~ Married6. (b) Name of husband or wife Ellen Caudill

Aline B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 19, 18838. AGE: Years 63 Months 4 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Alleghany Co., M. C.
(Town, county and state)10. Usual occupation Farmer11. Industry or business Crop Farming12. Name William D. Caudill13. Birthplace Alleghany Co., M. C.14. Maiden name Francis Crome15. Birthplace Alleghany Co., M. C.16. Informant Mr. Garfield CaudillAddress Belt Air, Md.17. Burial Date thereof Aug. 14, 1946
(Burial, cremation, or other) (month, day) (year)Cemetery or crematory Mt. Zion CemLocation Harford Co., Md.18. Funeral director H. J. BaileyAddress Washington Blvd.19. Aug. 12, 1946 M. D. Flork
(Date paid by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1946, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

INTRACRANIAL HEMORRHAGE
FRACTURE OF SKULL

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of Aug. 11, 1946Where did injury occur? NEAR CHURCHVILLE HARFORD MD.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) PUBLIC ROAD #136Means of Injury AUTO ACCIDENT Injured at work? NO

23. SIGNATURE

J. H. Ramsey M.D.
Address HERBEEEN, MD. Date signed Aug. 11, 1946

RECEIVED

AUG 24 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 08095 183

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Stewartstown Pa
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Marion K. Edie

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Bertha Edie7. Birth date of deceased (mo., day, yr.) Dec 12 1880 6.(c) If alive, give age 55 years8. AGE: Years 65 Months 8 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Stewartstown Pa
(Town, county, and state)10. Usual occupation Farming11. Industry or business Farming12. Name Arthur Edie13. Birthplace Stewartstown Pa14. Maiden name Letitia Burr15. Birthplace Harford Pa16. Informant Paul EdieAddress Stewartstown Pa17. Burial Date thereof Aug 22 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Normsville M. ChgoLocation Normsville Md18. Funeral director W. Howard WebbAddress Farm Grove Pa19. Aug. 22 19 46 Thos. R. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1946 at 5 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 19 46 to Aug 19 19 46and that I last saw him live on Aug 17 19 46Immediate cause of death Cerebral Thrombosis DURATION 30 minDue to Arterio Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ernest M. Free M. D. or other _____Address Stewartstown Pa Date signed Aug 19 46

RECEIVED

MAY 22 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2 X

CERTIFICATE OF DEATH

Reg. Dist. No. 08096 181

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

19.76, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug 28, 19.76

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED
AUG 8 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County Harford
 City or town Abingdon Bel Air R.D. #2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 1/2 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Abingdon Bel Air R.D. #2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Frederick Garsesche Farish

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) Sept 14, 1866 6. (c) If alive, give age _____ years
 8. AGE: Years 79 Months 11 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace St. Louis, Missouri
(Town, county, and state)10. Usual occupation Mining Engineer

11. Industry or business _____

12. Name Edward J. Farish13. Birthplace Woodville Miss14. Maiden name Lilly Garsesche15. Birthplace Wilmington Delaware16. Informant Edward J. FarishAddress 834 Eakin Rd, Manhasset N.Y.17. Transportation Date thereof Aug 16 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Robert KnappLocation 713 Chestnut St, St Louis Mo18. Funeral director Howard K. McCombsAddress Abingdon, Maryland19. Aug 16 19 46 Man M. Mouldale
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 19 46 at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Aug 14 19 46and that I last saw him alive on Aug 14 19 46Immediate cause of death arteriosclerotic heart disease DURATION 5 yrs

Due to _____

Due to Cancer of stomach Cause of Perforation 4 monthsOther conditions abdominal malignancy
etiology not known
(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Jed O. Hodous, M.D. M. D. or other _____Address Edgewood, Md Date signed 8-15-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 19 1946
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

CERTIFICATE OF DEATH

Reg. Dist. No. 08097 182

1. PLACE OF DEATH:

County... HarfordCity or town... Fallston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... HarfordCity or town... Fallston
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Oliver Hall.

3. (b) Social Security Number

4. Sex

M

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Jessie Harris

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years 72 Months ? Days ? If less than one day

..... hrs. min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual occupation

Farm laborer

11. Industry or business

Isaac Hall.

12. Name

Md.

13. Birthplace

Charletha Brown

14. Maiden name

Md.

15. Birthplace

Wm. A. Hall

16. Informant

Fallston, Md.

Address

Bureau

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Funeral

Cemetery or crematory

Benson

Location

Chas. E. Gross.

18. Funeral director

Benson, Md.

Address

8/719. (Date rec'd by registrar) 19. 46 Piscilla Towood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 19 46 339 M

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Arteriosclerotic C.V.disease

DURATION

3 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Derald C. Palmer M.D.Asst. Deputy Health OfficerHarford County

M. D. or other

Address Bel Air, Md.Date signed 8/7/46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1946

BUREAU V S.

1946
29
7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08098-185

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

23. SIGNATURE

M. D. or other

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

19..

at

19..

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
AUG 29 1944
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

08099

1. PLACE OF DEATH:

County Harford
 City or town Harbe de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Harbe de Grace, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Harford Memorial Hospital
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Baby Girl Hurley

3. (b) Social Security Number

New born

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Newborn

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

6

hrs.

min.

9. Birthplace

HARBE DE GRACE, HARFORD, MD
(Town, county, and state)

10. Usual occupation

New born

11. Industry or business

New born

FATHER

12. Name

Lawrence Hurley

13. Birthplace

MOTHER

14. Maiden name

Bernadine Williams

15. Birthplace

Harbe de Grace, Md

16. Informant

Hospital Records

Address

Harbe de Grace, Md

17. (Burial, cremation, or removal) Which

Burial

Date thereof

Aug 29 1946
(month) (day) (year)

Cemetery or crematory

St. James R. M. E.

Location

Harbe de Grace, Md

18. Funeral director

Elmer E. Bell

Address

536 Lewis St. Harbe de Grace

19. (Date read by registrar)

Aug. 28 1946G. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 2719.. 46

at

1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 2119.. 46

to

Aug 2819.. 46and that I last saw him alive on Aug 27 19.. 46

Immediate cause of death

Prematurity

DURATION

6 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Dr. G. L. Lewis

M. D. or other

Address.....

Date signed Aug 27 1946

UNITED STATES DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

RECEIVED

AUG 30 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

08100

Reg. Dist. No.

1. PLACE OF DEATH:

County HARFORDCity or town RURAL JARRETTSVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 WEEKS

Hospital, institution, or street address where death occurred:

JARRETTSVILLEHow long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County —City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 5100 Bluff Band St
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

JOHN M. JANKOWIAK

3. (b) Social Security Number

4. Sex M5. Color or race White6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife —6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) May 31 18958. AGE: Years 51 Months — Days — If less than one day — hrs. — min.9. Birthplace Balto. Ind.
(Town, county, and state)10. Usual occupation Labr11. Industry or business —12. Name John Jankowski13. Birthplace Poland14. Maiden name Rose Nawakowski15. Birthplace Poland16. Informant Mrs. Mary Weber sisterAddress 401 S. Chester Street17. Burial Date thereof 8-5-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Rosary CmnLocation Baltimore County18. Funeral director John M. WeberAddress 401 S. Chester Street19. P/2 46 Registrar —

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 1 1946, at 2:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —and that I last saw him — alive on — 19 —Immediate cause of death CORONARY OCCLUSION

DURATION

Due to —Due to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Antopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of Injury — Injured at work? —23. SIGNATURE J. H. Ramsey M.D.

DER. MED. EXAMINER M. D. or other

Address ABERDEEN MD. Date signed AUG. 1, 1946

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

100

WATER RESOURCES

SECTION

WV

2411 N. Charles St., Baltimore 170-4

08101

Reg. Diat. No. 181

1. PLACE OF DEATH: County <u>Harford</u> City or town <u>Aberdeen Proving Ground, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>1 year 6 months</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Louisiana</u> County <u>Tangipahoa</u> City or town <u>Hammond</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>General Delivery</u> (If rural, give LOCATION) 2.(a) If veteran, name war		
3.(a) FULL NAME <u>Willie Johnson</u>			3.(b) Social Security Number		
4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married			MEDICAL CERTIFICATION		
6.(b) Name of husband or wife <u>Lois Johnson</u>			20. DATE OF DEATH <u>August 12</u> 19 <u>46</u> at <u>1:15 P</u>		
7. Birth date of deceased (mo., day, yr.) <u>12 April 1925</u>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>19</u> to <u>19</u>		
8. AGE: Years <u>21</u> Months <u>4</u> Days <u>hrs.</u> min.			and that I last saw him alive on <u>August 12</u> 19 <u>46</u>		
9. Birthplace <u>Hammond, Louisiana</u> (Town, county, and state)			Immediate cause of death <u>Fracture, depressed, right parietal bone</u>		
10. Usual occupation <u>Soldier, U. S. Army</u>			DURATION		
11. Industry or business			Due to <u>Crushing in Automobile Accident</u>		
FATHER			Due to		
12. Name <u>Unknown</u>			Other conditions <u>Fractures of left arm and jaw</u>		
13. Birthplace <u>Unknown</u>			(Include pregnancy within 3 months of death)		
MOTHER			Major findings of operations		
14. Maiden name <u>Unknown</u>			Date of op.		
15. Birthplace <u>Unknown</u>			Autopsy results		
16. Informant <u>U.S. Army Records</u>			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
Address <u>Aberdeen Proving Ground Md.</u>			22. VIOLENCE: If death was due to external causes, fill in the following:		
17. Transportation <u>Transportation</u> Date thereof <u>Aug 13 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year)			Accident, suicide, or homicide <u>Automobile</u> Date of <u>12 August 4</u>		
Cemetery or crematory <u>Pacheco Funeral Home</u>			Where did injury occur? <u>Aberdeen Proving Ground</u> (City or town) (County) (State)		
Location <u>Hammond La</u>			Injured at home, farm, industry, public place (where?) <u>Military Reservation</u>		
16. Funeral director <u>Howard K. McCombs</u>			Means of Injury <u>Automobile Accident</u> Injured at work?		
Address <u>Aberdeen Maryland</u>			Undetermined		
19. (Date received by registrar) <u>Aug 28 19 46</u> <u>Nellie H. Riley</u> Registrar			23. SIGNATURE <u>Geo. Krumer</u> <u>1st Lt. M.C.</u> M. D. or other		
			Address <u>Station Hosp AFG</u> Date signed <u>12 Aug 46</u>		

CERTIFICATE OF DEATH

LOCAL BOARD OF HEALTH

IDENTIFICATION

RECEIVED
AUG 23 1946
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (702)

CERTIFICATE OF DEATH

Reg. Dist. No. 08102 181

1. PLACE OF DEATH:

County HARFORD
 City or town RURAL - PERRYMAN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
ABERDEEN - PERRYMAN ROAD
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Harre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 415 So. Stokes Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

WALTERJONES

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Baby

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9, 19418. AGE: Years Months Days It less than one day
4 11 26 hrs. min.9. Birthplace Harre de Grace, MD
 (Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Melvin Jones13. Birthplace Terre Haute, Indiana14. Maiden name Hazel Pindison15. Birthplace Perryman, Maryland16. Informant Mrs. Hazel JonesAddress 415 So. Stokes Street17. Burial Date thereof Aug 7, 1946
 (Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory St. James CemeteryLocation Harre de Grace, Maryland18. Funeral director Elmer E. BellAddress 556 Lewis St. Harre de Grace, MD19. Aug 7 19 46 Nellie Z. Riley
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 19 46 10:55 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Compound fracture of skull

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Aug 4, 1946Where did injury occur? NEAR PERRYMAN HARBOR MD

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) PUBLIC ROADMeans of Injury AUTO ACCIDENT Injured at work? No23. SIGNATURE J. H. Ramsey M.D.Address ABERDEEN, MD Date signed Aug 4, 1946

RECEIVED

AUG 26 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Diat. No. 180

1. PLACE OF DEATH:

County Harford Co.
City or town Beltscamp, Bel Air R.D. #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Beltscamp, Aberdeen R.D. #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Krumel

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Anna Krumel

7. Birth date of deceased (mo., day, yr.) Mar 11, 1872 6. (c) If alive, give age 69 years

8. AGE: Years 74 Months 4 Days 22 If less than one day
hrs. min.

9. Birthplace Austria, Europe
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Frank Krumel

13. Birthplace Austria, Europe

14. Maiden name Anna Vokach

15. Birthplace Austria, Europe

16. Informant Mrs Anna Krumel

Address Beltscamp, Aberdeen R.D. #2 Md

17. Burial (Burial, cremation, or removal, Which) Burial Date thereof Aug 6 1946
(month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore Maryland

18. Funeral director Howard K. McCombs, Inc

Address Abingdon Maryland

19. Aug 6 19 46 Frank M. Gaudet
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1946 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3, 1946 to Aug 3, 1946 and that I last saw him alive on Aug 3, 1946

Immediate cause of death coronary thrombosis DURATION 2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W K Dulaney M. D. or other

Address Aberdeen Md Date signed Aug 5 1946

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 9 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

08105

1. PLACE OF DEATH:

County HartfordCity or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HartfordCity or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hora May Leight Leight

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Joseph T. Leight7. Birth date of deceased (mo., day, yr.) June 22 1867 8. (c) If alive, give age 85 years8. AGE: Years 79 Months 2 Days - If less than one day _____ hrs. _____ min.9. Birthplace Magnolia Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Richard Robinson13. Birthplace Maryland14. Maiden name Elizabeth Howard15. Birthplace Maryland16. Informant Martha A. GlennAddress Magnolia Md17. Burial Date thereof Aug 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CatholicLocation Abingdon Maryland18. Funeral director Howard K. McCombsAddress Abingdon Maryland19. Aug 25 19 46 Marion Mackdale
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 19 46 at 1:30 p. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 45 to Aug 22 19 46
and that I last saw him alive on Aug 21 19 46Immediate cause of death Chronic glomerular nephritis

DURATION

3 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jed O'Hodora M.D.

M. D. or other

Address Edgewood, Md Date signed 8-22-46

RECEIVED
AUG 28 1945
BUREAU 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (200-0)

CERTIFICATE OF DEATH

08106

Reg. Dist. No. 182

1. PLACE OF DEATH:

County... Hagerford
 City or town... Bell Air, Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... Hagerford
 City or town... Bell Air, MD
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Mhucks

3. (b) Social Security Number

4. Sex F 5. Color or race Col 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Waymon Mhucks

7. Birth date of deceased (mo., day, yr.) 1907 8. (c) If alive, give age IN years

8. AGE: Years 39 Months Days If less than one day
 hrs. min.

9. Birthplace Florida SC
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name Henry Palmer
 13. Birthplace SC

14. Maiden name UNKNOWN
 15. Birthplace S.C.

16. Informant Waymon Mhucks
 Address Bell Air, MD

17. Burial Date thereof Aug 6 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Hendon Hill
 Location Water Valley Rd.

18. Funeral director Dean & Foster
 Address Bell Air, MD

19. 8/6 46 Priscilla Lowwood
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1946 at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19.... to 19....

and that I last saw h..... alive on 19....

Immediate cause of death.....

Pending InvestigationDue to Autopsy revealed no significantfindings; hence, cause of death remainsDue to Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results Pending Investigation

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide not known Date ofWhere did injury occur? not known (City or town) (County) (State)Injured at home, farm, industry, public place (where?) not knownMeans of injury Injured at work? noDerald C Palmer M.D.23. SIGNATURE acting Deputy Medical ExaminerAddress Bell Air, MD M. D. or otherDate signed 8/6/46

RECEIVED
AUG 8 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

Reg. Dist. No. 08107 185

1. PLACE OF DEATH:

County HarfordCity or town Harre Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harre Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. Clinton Street
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Sidney Hugh Mash

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anna Lucida Mash6. (c) If alive, give age 54 years

7. Birth date of

deceased (mo., day, yr.)

Nov 28 - 1887

8. AGE:

Years

Months

Days

If less than one day

58813

hrs.

min.

9. Birthplace

England

Town, county, and state

10. Usual occupation

Supt. Standard Limestone Co.

11. Industry or business

FATHER
MOTHER

12. Name

Alfred Mash

13. Birthplace

England

14. Maiden name

Annie Horsford

15. Birthplace

England

16. Informant

Anna Lucida MashAddress Clinton St. Harre Grace

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 13 - 1946
(month) (day) (year)

Cemetery or crematory

Dund Ridge

Location

Pikesville Maryland

18. Funeral director

Elesworth AmickAddress 3911 Liberty Heights Ave.

19. Date rec'd by registrar

8/13/46

1946

A. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1946, at 1:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 20 1945, to Aug 10 1946and that I last saw him alive on Aug 10 1946

Immediate cause of death

Acute Sclerosis
of the heart

DURATION

Due to

Cerebral Hemorrhage

Due to

Other conditions

Cachexia
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Foley, M.D.
M. D. or other
Address Harre Grace Date signed 8/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

CERTIFICATE OF DEATH

08108

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Shedden
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

110 Taft St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State North Carolina County Pfefferson
 City or town Forest City
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harriett McAfee

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Gordon McAfee7. Birth date of deceased (mo., day, yr.) October 21, 1883

8. (c) If alive, give age _____ years

8. AGE: Years 62 Months 9 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Georgia

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Dr. C. E. Evans13. Birthplace Georgia14. Maiden name Harriett Abernethy15. Birthplace Georgia16. Informant Mrs. Stacey MullAddress 110 Taft St.17. Removal Aug 8 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Morgantown, N.C.

Location _____

18. Funeral director Henry Tarrington JonesAddress Shedden, Md.19. Aug 8 1946 Nellie H. Riley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7, 1946, at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1946 to Aug 7, 1946 and that I last saw him alive on Aug 7, 1946

Immediate cause of death _____

DURATION

Intracranial HemorrhageDue to Brain Tumor

(cause & type unknown)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James H. Lammey 24.2.

M. D. or other

Address Aberdeen, Md. Date signed Aug 8, 1946

RECEIVED
AUG 26 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

Reg. Dist. No. 186-08109

1. PLACE OF DEATH: County <u>Harford</u> City or town <u>Harve de Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>3 days</u> Hospital, institution, or street address where death occurred <u>Harford Memorial Hospital</u> How long in hospital or institution? <u>3 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md</u> County <u>Harford</u> City or town <u>Harve de Grace</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>W. ARREN ST</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Joyce Merchant</u>				3. (b) Social Security Number			
4. Sex <u>F</u>		5. Color or race <u>C</u>		6. (a) Single, married, widowed, or divorced <u>S</u>			
6. (b) Name of husband or wife				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>March 16, 1946</u>				8. AGE: Years <u>12</u> Months <u>0</u> Days <u>0</u> If less than one day <u>hrs.</u> <u>0</u> min. <u>0</u>			
9. Birthplace <u>Harve de Grace, Maryland</u> (Town, county, and state)				10. Usual occupation <u>School girl</u>			
11. Industry or business				12. Name <u>William Merchant</u>			
13. Birthplace <u>Lynchburg, Virginia</u>				14. Maiden name <u>Beatrice Carter</u>			
15. Birthplace <u>Harve de Grace, Maryland</u>				16. Informant <u>Mrs Beatrice C. Merchant</u> Address <u>Warren St., Harve de Grace, Md</u>			
17. Burial (Burial, cremation, or removal, which?) <u>Sept 1, 1946</u> Cemetery or crematory <u>St. James Cemetery</u> Location <u>Harve de Grace, Maryland</u> 18. Funeral director <u>Elmer E. Bullock</u> Address <u>55 Lewis St. Harve de Grace, Md</u>				20. DATE OF DEATH <u>Aug 29</u> 19 <u>46</u> at <u>12</u> <u>28</u> <u>A.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Aug 29</u> 19 <u>46</u> to <u>Aug 29</u> 19 <u>46</u> and that I last saw <u>her</u> alive on <u>Aug 29</u> 19 <u>46</u> Immediate cause of death <u>Tetanus</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operation Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?..... 23. SIGNATURE <u>Dudley Thiggin</u> Address <u>Harford Mem. Hosp</u> Date signed <u>8/29/46</u>				DURATION <u>3 days</u>			

19. Sept 1 1946
 (Date rec'd by registrar)

Registrar

RECEIVED
SEP 4 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOT FOR CORPORATE USE ONLY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

08110

1. PLACE OF DEATH:
 County Hartford
 City or town Hamme de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 60 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Hartford
 City or town Hamme de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 551 Lewis Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James R. Mitchell

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Laura C. Mitchell
 7. Birth date of deceased (mo., day, yr.) Feb 11, 1874 6. (c) If alive, give age _____ years

8. AGE: Years 72 Months 6 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Paradise, Hartford, Md
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Lewis Mitchell

13. Birthplace Virginia

14. Maiden name Easter Robinson

15. Birthplace Virginia

16. Informant Mrs. Laura B. Mitchell

Address 551 Lewis St. Hamme de Grace

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 17, 1946
 (known) (day) (year)

Cemetery or crematory St. James Cemetery

Location Hamme de Grace, Md

18. Funeral director Elmer E. Bullfinch

Address 556 Lewis St. Hamme de Grace

19. 8-17 46 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 19 46 at 2:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-27-46 19 46 to 8-13 19 46

and that I last saw him alive on Aug 13 19 46

Immediate cause of death Chronic myocarditis DURATION 3-1-46

Due to

Due to

Other conditions Alumina 2-27-46

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Claude A. Brown M.D. M. D. or other

Address Hamme de Grace Date signed 8-17-46

RECEIVED
AUG 19 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

08111

1. PLACE OF DEATH:

County... HartfordCity or town... Aberdeen
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life - 65 yrs.

Hospital, institution, or street address where death occurred:

40 E. Belair Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... HartfordCity or town... Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. 40 E. Belair Ave.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Annie Virginia Osborn

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife S. Mitchell Osborn

7. Birth date of deceased (mo., day, yr.)

May 27, 18816. (c) If alive, give age 65 years

8. AGE:

Years 65 Months 2 Days If less than one day9. Birthplace... Aberdeen, Hartford Co., Md.

(Town, county, and State)

10. Usual occupation... Housewife

11. Industry or business

12. Name... Cyrus A. Courtney

13. Birthplace

Aberdeen, Md.

14. Maiden name

Annie Cole

15. Birthplace

Aberdeen, Md.16. Informant... S. Mitchell OsbornAddress... 40 E. Belair Ave.

17. Burial (Burial, cremation, or removal. Which?)

BurialDate thereof Aug 27 1946
(month) (day) (year)

Cemetery or crematory

Grove

18. Funeral director

Henry Tarrington & Sons

19. Address

Aberdeen, Md.

Date received by registrar

Aug. 27 1946Registrar Nellie F. Riley

Address

Aberdeen, Md.

23. SIGNATURE

YB Jastram MD

M. D. or other

Date signed

8-26-45

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25th 1946, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1943, to Aug. 1946and that I last saw him alive on Aug. 24 1946Immediate cause of death Cerebral Embolism

DURATION

Due to Hypertensive cardi-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

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AUG 28 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

08112

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH

County HarfordCity or town Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr - 8 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Joppa, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Franklin Parish

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Cynthia Parish

7. Birth date of deceased (mo., day, yr.)

Feb 14, 1865

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

81526

9. Birthplace

Scottdale north Caroline
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

FATHER

12. Name

Wesley

13. Birthplace

North Carolina

MOTHER

14. Maiden name

Bethany Thompson

15. Birthplace

North Carolina

16. Informant

V. P. Parish

Address

Joppa Maryland

17.

Transpiration
(Burial, cremation, or removal. Which?)

Date thereof

Aug 12 1946
(month) (day) (year)

Cemetery or crematory

Reins-Sturdivant Funeral Home

Location

North Wilkesboro N.C.

18. Funeral director

Howard K. McCombs

Address

Abingdon Maryland

19.

Aug 12 1946
(Date rec'd by registrar)

19.

Franklin Parish
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1946 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 9, 1946 to Aug. 10, 1946and that I last saw him alive on Aug 9, 1946

Immediate cause of death

Acute Bronchopneumonia

DURATION

2 days

Due to

Due to

Other conditions

Epithelioma of nose

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clifford F. Hudson MD.

M. D. or other

Address

Fork, Md.Date signed 8/10/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1120

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 64

RECEIVED
AUG 13 1946
BUREAU 7 S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 176

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County HARFORD
 City or town RURAL - PERRYMAN
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

ABERDEEN - PERRYMAN ROAD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Shore de Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 415 So. Stokes Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William H Pinion

3. (b) Social Security Number

220-03-3681

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male negro Mary E. Pinion

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1884

8. AGE: Years Months Days If less than one day

62 7 hrs. min.9. Birthplace Shore de Chase, Md
(Town, county, and state)10. Usual occupation Labourer

11. Industry or business

12. Name Levis Pinion13. Birthplace Shore de Chase, Md14. Maiden name Henrietta Pinion15. Birthplace Shore de Chase, Maryland16. Informant Mrs. Hazel YoungAddress 415 So. Stokes Street17. Burial Date thereof Aug 7, 1946
(Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory St. Ignace CemeteryLocation Shore de Chase, Md18. Funeral director Elmer E. BullittAddress 556 Levis St. Harwood, Md19. Aug 7 1946 Nellis H. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 4 1946 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

FRACTURE OF SKULLINTRACRANIAL HEMORRHAGE

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of AUG 4, 1946Where did injury occur? NEAR PERRYMAN HARF MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) PUBLIC ROADMeans of injury AUTO ACCIDENT Injured at work? NO23. SIGNATURE J. H. Ramsey M.D.

DEP. MED. EXAMINER M. D. or other

Address ABERDEEN MD Date signed AUG 4, 1946

1945-80-088

RECEIVED

AUG 26 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

Reg. Dist. No. 08114 181

1. PLACE OF DEATH:

County Harford
 City or town Aberdeen Proving Ground, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Four Months
 Hospital, institution, or street address where death occurred:
Station Hospital, Aberdeen Proving Ground, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Texas County Bexar
 City or town San Antonio
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 315 Holland Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Santos Lopez Ramos, Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race Mexican 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Paulita Garcia

7. Birth date of deceased (mo., day, yr.) 16 February 1927 8. (c) If alive, give age years

8. AGE: Years 19 Months 6 Days 4 If less than one day
 hrs. min.

9. Birthplace San Antonio, Texas
 (Town, county, and state)

10. Usual occupation Soldier, U. S. Army

11. Industry or business

12. Name Santos Lopez Ramos, Sr.13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant U.S. Army RecordsAddress Aberdeen Proving Ground Md.

17. Transportation Date thereof Aug 13, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Andrew MuralLocation 302 Durango, San Antonio Texas18. Funeral director Howard K. McCombsAddress Aberdeen Maryland

Aug. 20 19 46 Nellie F. Wiley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 18 to 19

and that I last saw him alive on 19

Immediate cause of death Contusion, cerebral, severe
 DURATION

Due to

Due to

Other conditions Fracture, humerus, left

Multiple lacerations
 (Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Automobile Date of 12 August 46

Where did injury occur? Aberdeen Proving Ground
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Military ReservationMeans of injury Automobile Accident Uninjured at work? undetermined23. SIGNATURE Samuel R. Mack M. D. or otherAddress Station Hospital, Aberdeen Md. Date signed 13 Aug 46Howard K. McCombs

CERTIFICATE OF DEATH

RECEIVED

AUG 23 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45100 CORPORATE LIMITS • MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 50 years
 Hospital, institution, or street address where death occurred:
about 50 years
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Harford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 726 Olsego Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Harriett Ann Richardson

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Lloyd Richardson

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1861 6. (c) If alive, give age 84 years

8. AGE: Years 84 Months 8 Days 22 If less than one day hrs. min.

9. Birthplace Churchville, Harford, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Henry W. Elsh

13. Birthplace Maryland

14. Maiden name Mary Keetley

15. Birthplace Maryland

16. Informant Mrs Rosa E. Eppes

Address 726 Olsego St. Harford, Md.

17. Burial, cremation, or removal (which) Burial Date thereof Aug 23, 1946
 (month) (day) (year)

Cemetery or crematory St. James Cemetery

Location Harford, Md.

18. Funeral director Elmer E. Dreller

Address 556 Lewis St. Harford, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19th 19 46 at 11 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 19 46 to Aug 19 19 46
 and that I last saw him alive on Aug 19 19 46

Immediate cause of death Cerebral hemorrhage DURATION 8-10-46

Due to arterio-sclerosis 9-6-38

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wanda H. Brown M. D. or other Wanda H. Brown
 Address Harford, Md. Date signed 8-20-46

19. Aug. 23, 46 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

RECEIVED

AUG 24 1945

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98-2

CERTIFICATE OF DEATH

08116

Reg. Dist. No. 182

1. PLACE OF DEATH

County Harford
City or town Rural Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? County Home 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Harford
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas Elsworth Singleton

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married divorced

6.(b) Name of husband or wife Elizabeth Singleton
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) _____ 1868

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Glenview Harford co md
(Town, county, and state)

10. Usual occupation Farm

11. Industry or business Retired

12. Name Elijah Thomas Singleton

13. Birthplace Glenview md.

14. Maiden name Hannah Griffith

15. Birthplace Havre de Grace md

16. Informant Mary E Preston

Address Shadowne md

17. Burial Date thereof Aug 20 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Trinity

Location Churchville md

18. Funeral director Martin G. Kuntz

Address Lanetteville md.

19. 8/28/46 46 Priscilla Fourwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 19 46 at 7:4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 - 19 46 to Aug 28 19 46

and that I last saw him alive on Aug. 21 19 46

Immediate cause of death Chr. Myocardial Disease

DURATION

3 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard P. Hudson

Forest Hill md M. D. or other _____

Address _____ Date signed 8/28/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 4 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 08117 181

1. PLACE OF DEATH:

County.....Harford
 City or town.....Rural Del. Cir.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....53 yrs.
 Hospital, institution, or street address where death occurred:
P. F. # 2
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Harford
 City or town.....Rural Del. Cir. P. F. # 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Cuswell
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....none

3. (a) FULL NAME

Frederick W. Smith

3. (b) Social Security Number

none

4. Sex.....Male 5. Color or race.....White 8. (a) Single, married, widowed, or divorced.....Widowed
 6. (b) Name of husband or wife.....Sarah C. Smith nee Oliver
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....Nov. 15 - 1862
 8. AGE: Years.....83 Months.....8 Days..... hrs. min.

9. Birthplace.....Harford Co. Md.
 (Town, county, and state)
 10. Usual occupation.....Farmer
 11. Industry or business.....Corn Canner
 12. Name.....Christian Smith
 13. Birthplace.....Germany
 14. Maiden name.....Elizabeth Sparkley
 15. Birthplace.....Germany

16. Informant.....Miss Mary S. Smith
 Address.....Del. Cir. Md. P. F. # 2
 17. Burial (Burial, cremation, or removal. Which?) Date thereof.....Aug 8, 1946
 (month) (day) (year)
 Cemetery or crematory.....Baker's
 Location.....Cheriden Md.

18. Funeral director.....Henry Thompson Sons
 Address.....Cheriden Md.
 19. Aug 7 - 46 (Date read by registrar) Nellie H. Wiley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Aug. 6 - 1946 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 6 1946, to Aug 6 1946.
 and that I last saw him alive on Aug 6 1946.

Immediate cause of death.....Cerebral hemorrhage

DURATION

3 hrs

Due to.....arteriosclerosis - hypertension

Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury..... Injured at work?.....

23. SIGNATURE.....Thos. P. Thompson M. D. or other
 Address.....Ardeen Date signed.....Aug 7/46

RECEIVED

AUG 26 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

081182
Reg. Dist. No.

1. PLACE OF DEATH:

County HarfordCity or town Bel-air Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Rural Bel Air
(If outside city or town limits, write RURAL and give nearest town)Street No. Hickory
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank M. Strickland

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed Married6.(b) Name of husband or wife Wirkke J Strickland
Alma7. Birth date of deceased (mo., day, yr.) Aug 2, 1882 6.(c) If alive, give age _____ years8. AGE: Years 64 Months 7 Days 15 It less than one day _____ hrs. _____ min.9. Birthplace New Port M. H.
(Town, county and state)10. Usual occupation Charlton11. Industry or business Lawyer12. Name Henry S. Strickland13. Birthplace Dorchester M. Co.14. Maiden name Mary M. Barr15. Birthplace Dorchester M. Co.16. Informant Mrs. Frank StricklandAddress Bel-air, Md.17. Remove Date thereof Aug 19, 1946
(Burial, cremation, or removal, write)Cemetery or crematory Plymouth N. H.18. Funeral director H. S. BaileyAddress Darlington, Md.19. 8/17/46 19. 46 Piscilla Lowndes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946, at 3:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to August 17 1946and that I last saw him alive on August 17 1946Immediate cause of death Chronic cholecystitis
with stones.Operated on July 17, 1946

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Chronic cholecystitis with stonesDate of op. July 17, 1946

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Willard R. HudsonAddress Forest Hill, Maryland Date signed 8/17/46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 24 1946

BUREAU V.B.

ATTESTANCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08119

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

December 12, 1945

8. AGE:

Years

Months

Days

If less than one day

7

..... hrs.

..... min.

9. Birthplace.....

Harford Co., Md.

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business.....

None

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date received by registrar)

1946

Nellie Z. Riley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

August 2, 1946

at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 25, 1946

to Aug. 2, 1946

and that I last saw him alive on Aug. 2, 1946

Immediate cause of death.....

Whooping Cough
Lobular Pneumonia

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Hiram B. Stuenkel

M. D. Physician

Address.....

Perryman, Md. Date signed Aug. 2, 1946

MARGIN RESERVED FOR BINDING

VS A16

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 26 1946
BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 150

1. PLACE OF DEATH:

County Harford
 City or town Joppa
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 46 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Joppa
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Thomas
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Sophia Thomas
 6.(c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) Dec 23, 1866

8. AGE: Years 77 Months 7 Days 18 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Retired Landscaper Gardener

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant Mrs Sophia Thomas

Address Joppa, Maryland

17. Buried Date thereof Aug 14 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grundy Lutheran

Location Joppa, Md

18. Funeral director Robert E. McCombs & Son

Address Abingdon Maryland

19. Aug 12 19 46 Marie M. Spaulding
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 19 46 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19____, to 19____
 and that I last saw him alive on 19____

Immediate cause of death Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D.
Acting Deputy Medical Examiner
Harford County M. D. or other

Address Baltimore, Md. Date signed 8/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 13 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1372

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HarfordCity or town Valle
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Rural - Forest
(If outside city or town limits, write RURAL and give nearest town)Street No. Waterfall
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry TURNER

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

B. (b) Name of husband or wife

ANNIE R C Turner

7. Birth date of deceased (mo., day, yr.)

Mar 16, 1873

6. (c) If alive, give age years

8. AGE:

73

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Balto., Co., Md
(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

FarmFATHER
MOTHER

12. Name

Thomas Turner

13. Birthplace

Md

14. Maiden name

Mary Bird

15. Birthplace

Md

16. Informant

ANNIE R C TURNER

Address

Fallston, Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Aug 24/46
(month) (day) (year)

Cemetery or crematory

Mountain Christian

Location

Joppa Road

18. Funeral director

Diana Foster

Address

Bellin md

19. (Date rec'd by registrar)

8/23

19.

46Winella Towood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22nd 1946 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 15 1946 to Aug 22 1946and that I last saw him alive on Aug 22 1946

Immediate cause of death

PROSTATIC HYPERTROPHY

DURATION

>

Due to

URINARY RETENTION (CHR)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

Address

Forest Hill, Md

Date signed

8/23/46

RECEIVED
AUG 27 1946
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08122



Reg. Dist. No. 185-

1. PLACE OF DEATH:

County HarfordCity or town Harford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address, where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2 Mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Perryman
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

717-07-5408

3. (a) FULL NAME

Herman C. Wissing

4. Sex

M.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife

Emma G. Wissing

7. Birth date of deceased (mo., day, yr.)

Aug. 17, 1890

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

5511

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

P. R. R. Fireman

11. Industry or business

FATHER

12. Name

Peter Wissing

13. Birthplace

Delaware

14. Maiden name

Emma Tibbie

15. Birthplace

Maryland

16. Informant

Mrs. Herman C. Wissing

Address

Perryman Md

17.

(Burial, cremation, or removal. Which?)

Date thereof Aug. 11-1946
(month) (day) (year)

Cemetery or crematory

Speetia

Location

Perryman Md

18. Funeral director

Henry Janning Sons

Address

Cherryman Md

19.

(Data rec'd by registrar)

19

A. L. Lewis M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 46 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 46 to Aug 9 19 46and that I last saw him alive on Aug 8 19 46Immediate cause of death Permia

DURATION

Due to

Carcinoma of head of pancreas
+ Curvature of spine

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Cc head of pancreas

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

YB Jastrow M.D.

M. D. or other

Address

Aberdeen MdDate signed 8-10-46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Date of death

RECEIVED
AUG 13 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

08123

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Darlington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 mo
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town coopersville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. —
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower
 6. (b) Name of husband or wife Elizabeth F Durham
 6. (c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) Apr 6th 1960
 8. AGE: Years 86 Months 4 Days 23 If less than one day — hrs. — min.

9. Birthplace Farm Balto co md
 (Town, county, and state)
 10. Usual occupation Farm Laborer

11. Industry or business

FATHER 12. Name Christopher Young
 13. Birthplace Germany
 MOTHER 14. Maiden name Barbara Daylor
 15. Birthplace Germany

16. Informant Walter C Young
 Address Darlington md

17. Burial Date thereof Sept 1-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory new watter
 Location Coopersville Harford co md

18. Funeral director Martin & Kirk
 Address Jarrettsville md.

19. Aug. 30 19 46 M. W Kirk
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 19 46 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 19 46 to Aug 29 19 46
 and that I last saw him alive on Aug 29 19 46

Immediate cause of death Cerebral Hemorrhage DURATION 20 hrs

Due to Arterio Sclerosis 3 yrs

Due to Chronic Hypertension

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. P. Woodgrass M. D. or other
 Address Warlington md Date signed 8/30/46

RECEIVED
SEP 19 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No.

08124

182

1. PLACE OF DEATH:

County Harford
 City or town Rural Bel Air
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 days - County Home

3. (a) FULL NAME

Joseph Young

3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Mollie Fleming

7. Birth date of deceased (mo., day, yr.)

March - 1884

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

625—— hrs.

min.

9. Birthplace

Harford Balto. Co. Md.
(Town, county, and state)

10. Usual occupation

Farm Laborer

11. Industry or business

FATHER

12. Name

John Young

13. Birthplace

not known

MOTHER

14. Maiden name

Rachel

15. Birthplace

not known

16. Informant

Helen Winston

Address

2535 N Howard St Baltimore

17. Burial

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Sept 2-46
(month) (day) (year)

Cemetery or crematory

Fairview

Location

Forest Hill Harford Co Md

18. Funeral director

Martin Edwards

Address

Janettsville Md.

19.

(Date rec'd by registrar)

19.

9/1 46 Puella Howard

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HarfordCity or town Janettsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 19 46 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 19 46 to Aug 30 19 46and that I last saw him alive on Aug 28 19 46

Immediate cause of death

Cerebral Hemorrhage
terminating

DURATION

10 daDue to Hypertensive Cardi-Due to Vascular Disease 8 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Willard P. Hudson

M. D. or other

Address Forest Hill Md Date signed 8/30/46

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